CENTRAL DISTRICT HEALTH DEPARTMENT

☐ Boise Office 707 N. Armstrong Place, Boise, ID 83704 Phone (208) 327-7450
☐ Mountain Home Office 520 E. 8th N. Street, Mt. Home ID 83647 Phone (208) 587-4407
☐ McCall Office 703 North 1st, McCall ID 83638 Phone (208) 630-8002

*To improve the health of our communities by identifying sustainable solutions to community health issues, developing partnerships for implementation of strategies, and demonstrating our success through measurement of outcomes.*

## CLIENT INFORMATION (PLEASE PRINT)

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Age: _____ Gender: M or F

Mailing Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

Email address: _____ (for reminder recall only)

Parent or Guardian name: _____
(when applicable)

**MEDICARE/MEDICAID INFORMATION:**

Medicaid#_____

Medicare/RR# _____ Insured Id#_____

Company: _____ Group #_____

**Circle all that apply** *Ages 0-18 yrs only*
Medicaid / No Insurance / Insurance / American Indian / Alaskan Native

**FINANCIAL POLICY: Effective September 8, 2008**

**INSURANCE:** We no longer bill insurance for immunization services. Payment is expected at time of service. If you wish to bill your insurance company, please ask for information at check-out.

**MEDICAID:** Please present your Medicaid card at check-in. Non-covered services will be your responsibility.

**MEDICARE:** We are not a Medicare provider. Payment is expected at time of service. We will send your bill to Medicare, but only **FLU** and **PNEUMONIA** will likely be covered. Other services will probably not be reimbursed by Medicare. Questions about your coverage should be directed to Medicare.

**No childhood immunizations will be denied due to inability to pay. Please ask for information at check-in.**

**FOR OFFICE USE ONLY** Payment Category: Staff initials: _____

Cash ☐ Credit/Debit Card ☐ Check Number _____ 3rd Party Billing Company Name _____ Slide ☐

# Please complete other side

Revised 9/10/08

| **SCREENING QUESTIONNAIRE FOR INJECTABLE INFLUENZA VACCINATION**<br>**For adult patients as well as parents of children to be vaccinated.**<br>The following questions will help you determine if there is any reason we should not give you or your child injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it. | YES | NO |
|---|---|---|
| IS THE PERSON TO BE VACCINATED TODAY MODERATELY OR SEVERLY ILL? | | |
| DOES THE PERSON TO BE VACCINATED HAVE AN ALLERGY TO CHICKEN EGGS OR TO A COMPONENT OF THE VACCINE? | | |
| HAS THE PERSON TO BE VACCINATED EVER HAD A SERIOUS REACTION TO **INFLUENZA** VACCINE IN THE PAST? | | |

**ALL CLIENTS PLEASE READ THE FOLLOWING AND CHECK APPROPRIATE BOXES**

I give permission to enroll me or my child and to transfer my or my child's immunization records into the Idaho Immunization Reminder Information System (IRIS) to ensure that this vaccination record is available to me, or my child's health care providers, and schools. I understand I may be asked for information that will help ensure my or my child's records are accurate and will not be confused with another person's records, such as: mother's maiden name, telephone number, child's gender, and child's eligibility for free vaccine. I authorize inclusion of all information into IRIS.

☐ NO (do not enroll me/my child in IRIS)

☐ I hereby acknowledge that I was given a copy and I have read or had explained to me the Central District Health Department Notice of Privacy Practices.

☐ Immunization Release of Information—This release is in effect for 1 year from date below. This release may be revoked at any time by a signed, written statement from the patient or responsible party.

☐ I have read or have had explained to me the information form about **influenza** vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine, and request the vaccine be given to me or to the person named for whom I am authorized to make this request.

☐ YES, I will be returning to CDHD for immunizations. ☐ NO, I routinely receive immunizations from my physician.

Signature of person receiving vaccine or the person authorized to make the request:

**SIGNATURE X**_____ **DATE**_____

**Date** _____

**Nurse Signature** _____

**Return Date** _____

**(FOR NURSES USE ONLY)**